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(2) Certification. Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(d) *Comprehensive care plans.* (1) The facility management must develop an individualized comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following—

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under § 51.120; and

(ii) Any services that would otherwise be required under § 51.120 of this part but are not provided due to the resident's exercise of rights under § 51.70, including the right to refuse treatment under § 51.70(b)(4) of this part.

(2) A comprehensive care plan must be—

(i) Developed within 7 calendar days after completion of the comprehensive assessment;

(ii) Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and

(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.

(3) The services provided or arranged by the facility must—

(i) Meet professional standards of quality; and

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.

(e) *Discharge summary.* Prior to discharging a resident, the facility management must prepare a discharge summary that includes—

(1) A recapitulation of the resident's stay;

(2) A summary of the resident's status at the time of the discharge to in-

clude items in paragraph (b)(2) of this section; and

(3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

(Authority: 38 U.S.C. 101, 501, 1710, 1741–1743)

§ 51.120 Quality of care.

Each resident must receive and the facility management must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

(a) *Reporting of Sentinel Events*—(1)

Definition. A sentinel event is an adverse event that results in the loss of life or limb or permanent loss of function.

(2) Examples of sentinel events are as follows:

(i) Any resident death, paralysis, coma or other major permanent loss of function associated with a medication error; or

(ii) Any suicide of a resident, including suicides following elopement (unauthorized departure) from the facility; or

(iii) Any elopement of a resident from the facility resulting in a death or a major permanent loss of function; or

(iv) Any procedure or clinical intervention, including restraints, that result in death or a major permanent loss of function; or

(v) Assault, homicide or other crime resulting in patient death or major permanent loss of function; or

(vi) A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall.

(3) The facility management must report sentinel events to the director of VA medical center of jurisdiction within 24 hours of identification. The VA medical center of jurisdiction must report sentinel events by calling VA Network Director (10N 1-22) and Chief Consultant, Geriatrics and Extended Care Strategic Healthcare Group (114) within 24 hours of notification.

(4) The facility management must establish a mechanism to review and

analyze a sentinel event resulting in a written report no later than 10 working days following the event. The purpose of the review and analysis of a sentinel event is to prevent injuries to residents, visitors, and personnel, and to manage those injuries that do occur and to minimize the negative consequences to the injured individuals and facility.

(b) *Activities of daily living.* Based on the comprehensive assessment of a resident, the facility management must ensure that—

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to—

- (i) Bathe, dress, and groom;
- (ii) Transfer and ambulate;
- (iii) Toilet;
- (iv) Eat; and
- (v) Talk or otherwise communicate.

(2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (b)(1) of this section; and

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, hydration, grooming, personal and oral hygiene, mobility, and bladder and bowel elimination.

(c) *Vision and hearing.* To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident—

(1) In making appointments, and

(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

(d) *Pressure sores.* Based on the comprehensive assessment of a resident, the facility management must ensure that—

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

(e) *Urinary and Fecal Incontinence.* Based on the resident's comprehensive assessment, the facility management must ensure that—

(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;

(2) A resident who is incontinent of urine receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible; and

(3) A resident who has persistent fecal incontinence receives appropriate treatment and services to treat reversible causes and to restore as much normal bowel function as possible.

(f) *Range of motion.* Based on the comprehensive assessment of a resident, the facility management must ensure that—

(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

(g) *Mental and Psychosocial functioning.* Based on the comprehensive assessment of a resident, the facility management must ensure that a resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem.

(h) *Enteral Feedings.* Based on the comprehensive assessment of a resident, the facility management must ensure that—

(1) A resident who has been able to adequately eat or take fluids alone or with assistance is not fed by enteral feedings unless the resident's clinical condition demonstrates that use of enteral feedings was unavoidable; and

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(2) A resident who is fed by enteral feedings receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers and other skin breakdowns, and to restore, if possible, normal eating skills.

(i) *Accidents.* The facility management must ensure that—

(1) The resident environment remains as free of accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(j) *Nutrition.* Based on a resident's comprehensive assessment, the facility management must ensure that a resident—

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and

(2) Receives a therapeutic diet when a nutritional deficiency is identified.

(k) *Hydration.* The facility management must provide each resident with sufficient fluid intake to maintain proper hydration and health.

(l) *Special needs.* The facility management must ensure that residents receive proper treatment and care for the following special services:

- (1) Injections;
- (2) Parenteral and enteral fluids;
- (3) Colostomy, ureterostomy, or ileostomy care;
- (4) Tracheostomy care;
- (5) Tracheal suctioning;
- (6) Respiratory care;
- (7) Foot care; and
- (8) Prostheses.

(m) *Unnecessary drugs—*(1) *General.* Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

- (i) In excessive dose (including duplicate drug therapy); or
- (ii) For excessive duration; or
- (iii) Without adequate monitoring; or
- (iv) Without adequate indications for its use; or

(v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(vi) Any combinations of the reasons above.

(2) *Antipsychotic Drugs.* Based on a comprehensive assessment of a resident, the facility management must ensure that—

(i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and

(ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

(n) *Medication Errors.* The facility management must ensure that—

(1) Medication errors are identified and reviewed on a timely basis; and

(2) strategies for preventing medication errors and adverse reactions are implemented.

(Authority: 38 U.S.C. 101, 501, 1710, 1741–1743)

§51.130 Nursing services.

The facility management must provide an organized nursing service with a sufficient number of qualified nursing personnel to meet the total nursing care needs, as determined by resident assessment and individualized comprehensive plans of care, of all patients within the facility 24 hours a day, 7 days a week.

(a) The nursing service must be under the direction of a full-time registered nurse who is currently licensed by the State and has, in writing, administrative authority, responsibility, and accountability for the functions, activities, and training of the nursing services staff.

(b) The facility management must provide registered nurses 24 hours per day, 7 days per week.

(c) The director of nursing service must designate a registered nurse as a supervising nurse for each tour of duty.

(1) Based on the application and results of the case mix and staffing methodology, the director of nursing may serve in a dual role as director and as an onsite-supervising nurse only when the facility has an average daily occupancy of 60 or fewer residents in nursing home.